Achieving Equities for Native American Communities
A Summary of the Tribal Projects

Chapter I
Achieving Equities for Native American Communities Workgroup

The workgroup is an ongoing tribal-state effort to mitigate the health, social and economic disparities experienced by tribal communities through the implementation of community-based prevention strategies. The workgroup was established, by consensus of the participants, at the November 2008 DHS-Tribal Consultation meeting. The following workgroup objectives have been identified:

- Distill the complex and interactive social, economic, legal and cultural factors that contribute to the resulting disparity milieu into a set of clearly defined and measurable outcomes;
- Unify and coordinate tribal, departmental, state, county and private entities' efforts to eliminate or mitigate the causes of inequities within Native American communities;
- Build a consensus on intervention strategies and practices that will translate into recommendations for specific programming, policy and funding initiatives to be carried out by tribal, county and state government.

The workgroup, comprised of tribal representatives and DHS/DCF staff, has adopted an intervention model, a strategic framework methodology and a community engagement process that has been piloted in tribal communities. This effort is grounded in the following assumptions:

- Significant improvement in the disparities experienced by tribal communities will require individual changes in attitude, belief systems and behavior;
- Individual behavioral change will become more likely and sustainable when supported by healthful family and community norms;
- Community change can only be achieved when communities and community leaders are engaged fully, honestly and respectfully;
- Intervention strategies must be compatible with individual and community readiness to change.

The following material outlines the processes that have been adapted for replication in tribal communities. These processes have been employed in pilot projects undertaken by the Menominee Nation and Red Cliff Band. Information specific to these tribal initiatives are included in Appendix A.

Chapter II
Inequities within Native American Communities

Native American communities within Wisconsin continue to experience significant negative disparities in a wide range of health, social, economic and service access categories. The complex interaction of the causes and effects of these biopsychosocial dynamics tend to perpetuate conditions which foster continued inequities and frustrate simple solutions. The interplay of conditions such as high rates of unemployment, poverty, educational underachievement, unacceptable health outcomes, environmental challenges and social marginalization are overlaid upon individual and collective trauma.
The inequities experienced by tribal communities are well documented. An abbreviated list of these disparities includes:

- The highest rates of heart disease related deaths compared to all races in Wisconsin; (60% higher than national rates)[1]
- Diabetes related mortality rates 298% higher compared to all races in Wisconsin;[2]
- Death rate from tuberculosis (600%), alcoholism (510%), motor vehicle crashes (229%), unintentional injuries (152%) higher than other Americans;[3]
- Rates of suicide are 3.3 times higher nationally for males between the ages of 15-24;
- Rates of overweight children ages 5-18 of 22%;
- Birth rates to teenage girls at a rate of 3.9 times higher than births to white teenagers; [4]
- High school graduation rates lower than that of rates for all races and attainment of a Bachelor's degree or higher at rates less than 50% as for all races in Wisconsin;
- Children raised in single family homes at a rate 3 times higher than that for all races within Wisconsin;
- Victimization by a violent crime at a rate more than two times higher the national average, according to a 1999 U.S. Justice Department report. A report by Amnesty International states that Native American women are more than 2.5 times more likely to be raped than women in the general U.S. population;
- Indian Health Services provided only 55% of the necessary federal funding to assure mainstream personal health care for Native Americans;
- National statistics show that more than 36% of Native Americans earning less than 200% of the federal poverty level had no health insurance;
- 2000 U.S. census figures show that unemployment among Native Americans in Wisconsin was 2.6 times higher than the rate for all races;
- The 2000 U. Census reports that 21.7% of Native Americans in Wisconsin lived in poverty as compared to 8.7% for all races in the state.

There is no one cause for the disparities faced by tribal communities. However, it is widely accepted that the disparities milieu evolves from a historical and socioeconomic experience unique to indigenous people and tribal communities. That is, the differential of wellbeing

[1]The Health of Racial and Ethnic Populations in Wisconsin: 1996-2000, Wisconsin Department of Health and Family Services.
[2] Community Health Profile: Minnesota, Wisconsin and Michigan Tribal Communities 2006, Great Lakes EpiCenter, Great Lakes Inter-Tribal Council.
[3] Facts on Indian Health Disparities, Indian Health Services.
[4] Births to Teens, Wisconsin Department of Health and Family Services, 2006.

experienced by tribal communities and dominate culture can be explained by the historic and ongoing trauma affecting indigenous people.

Chapter III
Historic Trauma

The current literature regarding health, social and economic disparities facing tribal communities point to a wide range of stressors that have their roots in history and, to greater or lesser degrees, continue to exert a negative influence on the well being of indigenous people. These historic experiences include, but are not limited to:

- Dispossession of tribal lands and repeated forced relocation;
- Repeated attempts to assimilate tribal people into the dominate culture through the systematic destruction of traditional language, customs, spiritual expression and self-governance;
- Genocidal warfare, exposure to disease and the destruction of indigenous societies that devastated tribal Nations;
- Forced removal of Indian children from their families and placement in boarding schools;
- The wholesale destruction of a centuries-old sustainable economy;
- Failure of the federal government to honor the treaty responsibilities to assure the provision of the health, educational and economic needs of signatory Native American Nations;
- Institutional racism and the social/economic marginalization of Native people.

These experiences have (and continue to have) emotional, psychological, spiritual, physical and social implications both on an individual and the collective community level. The historical trauma inflicted on tribal communities has resulted in:

- A breakdown of family, extended family (clan) and social relationships;
- Sexual exploitation of women and loss of traditional gender roles;
- Loss of interdependent economic and social support structures resulting in an economy dependent upon the dominate culture;
- Distorted/weakened individual and collective identity (often referred to as internalized oppression or concentration camp syndrome);
- Unresolved multigenerational grief;
- Lack of acculturation of youth in traditional values.

In order to fully appreciate the destructive power inherent in the historical trauma experienced by Native American people and the difficulty in reducing the resulting disparities, one must understand that:

- Trauma is multigenerational. The emotional, physical and psychological effects of trauma are passed on to subsequent generations;
- The undermining of the Native Community's social fabric weakens the community's as well as the individual's ability to heal;
- Genocide is not just a part of history: it continues in many subtle and not so subtle ways to perpetuate the wound;

- The symptoms (disparities) re-traumatizes the individual and community, further weakens the social support system and perpetuates the trauma cycle;
- The majority of programs, especially non-tribal services, are directed at mitigating the symptoms rather than healing the causes (trauma).

Chapter IV
Social-Ecological Model

The Social – Ecological Model is based on the understanding that health promotion includes not only educational activities but also advocacy, organizational change efforts, policy development, economic supports, environmental change, and multi-method strategies (*Theory at a Glance*, National Cancer Institute, 2005). This ecological perspective highlights the importance of approaching public health problems at multiple levels and stressing interaction and integration of factors within and across levels. The social-ecological model has five successively more complex levels (or spheres) of influence (examples are related to physical activity and nutrition):

Intrapersonal or individual factors: These factors include individual characteristics that influence behavior such as knowledge, attitudes, beliefs, and personality traits.
Examples of intervention include:
- Organize the public to request healthy choices at fast food restaurants;
- Educate the public about ways to impact on fast food corporate offices to increase healthy choices;
- Educate the public about ways to impact on inappropriate media messages about food and physical activity.

Interpersonal factors: These factors are made up of relational processes within an individual's primary groups such as family, friends, and peers. These relationships provide social identity, support, and role definition.
Examples of interventions include:
- Implement a social marketing plan;
- Target interventions where people work and learn, play and pray;

Institutional factors: Institutional factors are made up of the rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviors.
Examples of interventions include:
- Impact on the medical system to achieve consistent assessment and intervention related to physical activity and nutrition;
- Improve access to nutrition and physical activity counselors;
- Adopt school policies that support regular physical activity and healthy food choices
- Turn off soda machines in schools;
- Provide universal breakfast in school;
- Identify vendors to pilot and evaluate the effect of increasing the price of unhealthy foods and decreasing the price of health foods.

Community factors: Community factors consist of social networks and norms, which exist formally or informally among individuals, groups, and organizations.

Examples of interventions include:

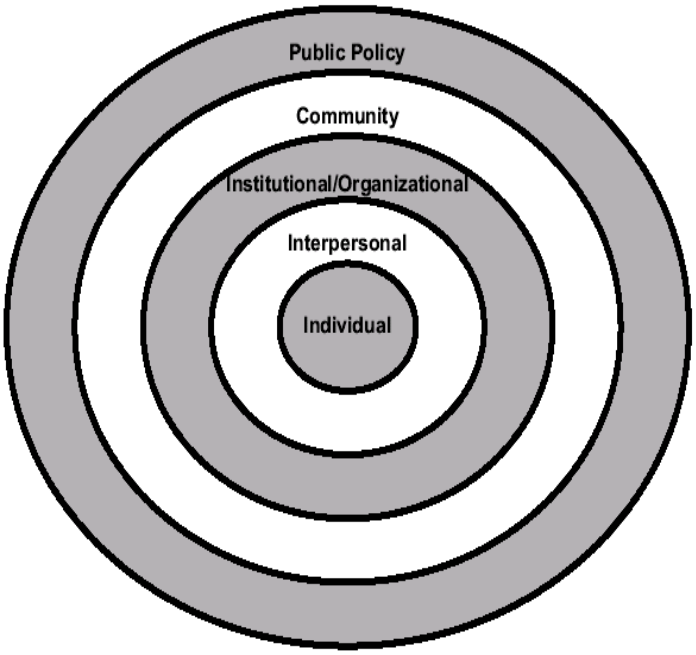
- Increase the number of partners involved in improving population health through nutrition and physical activity strategies. They will participate in the planning and be essential resources in the implementation;
- Implement environmental changes that make the desired behavior or protection passively happen (community design to support activity or only offering healthy snacks at meetings) or make the desired behavior or protection easier to achieve (such as biking and walking trails or healthy choices in vending machines);
- Develop healthy policies and determine of enforcement is reasonable.

Public policy: An important and often essential element of creating sustainable change involves local, state, and federal policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control, and management.
Examples of interventions include:

- Educate legislators about policies that improve nutrition and increase physical activity;
- Influence statewide public health organizations to include policies to improve nutrition and increase physical activity on their legislative agendas;
- Educate and engage local policy makers in supporting healthy environmental policy changes;
- Utilize local officials (mayors, town and county officials) to influence their communities;
- Influence local partners to focus on these issues in their spheres of influence and advocate for healthy policies and personal choices though their communication routes, such as, parent teacher groups, newsletters, luncheon speakers and the policies they adopt for themselves;
- Develop policies to support breastfeeding at the hospital, at work and in the community;
- Provide mini-grants to partners to undertake projects to meet proposal objectives;
- Policy changes can be formal laws, policies of organizations or informal expectations that groups have about certain health behaviors.

The Social-Ecological model recognizes that sustainable individual behavior change is most likely to occur when effective interventions target each of the spheres described above and indicated in the diagram below.

A Social-Ecological Model for Levels of Influence



Public Policy: local, state, and federal government policies, regulations, and laws

Community: social networks, norms, standards and practices among organizations

Institutional/Organizational: rules, policies, procedures, environment, and informal structures within an organization or system

Interpersonal: family, friends, peers that provide social identity, support and identity

Individual: awareness, knowledge, attitudes, beliefs, values, preferences

Based on data from McElroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. Health Education Quarterly 15:351-377, 1988.

Chapter V
Prevention Intervention Framework

The intervention framework identifies best practice strategies that can be employed in the five domains of the Social Ecological Model (individual, interpersonal, community, institution and public policy) for three stages of prevention and control:

- *Primary Prevention*: These strategies are targeted towards healthy individuals with the intention of preventing the undesired disease, behavior or condition;
- *Secondary Prevention:* These strategies are aimed at screening, early diagnosis and treatment activities to prevent or delay onset of the condition;
- *Tertiary Prevention:* Tertiary interventions strategies attempt to delay disability or premature death for those individuals who have the disease/condition.

The framework format can be adapted to address a wide variety of health or social issues. Each community will identify, prioritize and build consensus on the issues to be addressed. Specific strategies are selected, for each stage of prevention, which have been shown to be effective locally or are acknowledged best practice methodologies. The implementation of specific strategies will be guided, in part, by the community's level of readiness. The community's level of readiness will be established through the community assessment and engagement activities.

Chapter VI
Community Engagement

Community Readiness: If we hope to successfully initiate prevention activities aimed at enhancing the health and wellbeing of individuals, it is essential that we are cognizant of the social and cultural environmental context within which they live. That is, we must take into consideration the community attitudes, behaviors and resources that support or resist the desired changes. To that end, it is important that we gauge the readiness of communities to acknowledge the issues at hand and mobilize the required actions to address these issues. The premise behind the community readiness model is a blend of two basic concepts; the psychological readiness for change and the principles of community development.

Over recent years, there have been several models developed that are designed to gauge a community's level of readiness to address local social, economic and health issues. Each of these models present benefits and drawbacks, but generally speaking there are several elements that are common to all models:

- Successful community efforts must be specific to the community, be culturally relevant and be consistent with the community's level of readiness for change;
- Successful models will provide methods for assessing the community's level of readiness, engaging community members/leaders, enhancing the community's level of readiness and building a sustainable change process.

The Community Readiness Model provides:

- A methodology for assessing a community's readiness to address specific issues;
- A means of engaging communities by building consensus, defining needs within the context of the community and enhancing community investment in key prevention/intervention strategies;
- A mechanism for building community partnerships and integrated service delivery,
- A means and methods for measuring outcomes;
- A guide to leading complex community change processes;
- A framework for subsequent prevention/intervention strategies;
- A means of matching appropriate interventions to a community's level of readiness and a way to enhance a community's level of readiness;
- A way to mobilize and coordinate community energy towards positive change.

Typically the steps involved in the application of a community readiness model include:

- Define the problem to be addressed, establish benchmarks and measurable goals;
- Establish/train a core group of community members/stakeholders committed to addressing the problem (Community Action Committee);
- Conduct/score an assessment of the community's level of readiness;
- Create a sustainability plan;
- Develop intervention strategies appropriate to the community's needs and level of readiness;
- Establish a data collection and continuous evaluation process.

Community Engagement: Community engagement is seen as the key to the successful facilitation of health promotion, economic development and social justice initiatives. The basic principles of community engagement provide a philosophy and working framework for the implementation of specific programming activities. Although the list of principles varies with the author, the CDC/ATSDR Committee on Community Engagement suggests:

- *Social Ecology*: The necessity of embracing the notion that an individual's potential for change must be considered within the context of their social, economic, cultural and political world. Institutions, governmental bodies, social networks, spiritual/religious systems and local environmental factors influence individual behavior, beliefs and attitudes;
- *Cultural influences*: Culture influences individual and communal perceptions, preferences and social practices. Any strategy that is in conflict with basic cultural norms is doomed for failure. Conversely cultural patterns can guide practices and processes that are more likely to succeed;
- *Community participation*: Strategies, regardless of how well intended, are more likely to succeed if individuals and the community is seen not just as a resource, but the driving force behind change;
- *Community empowerment*: Empowerment begins with the belief that individuals, institutions and communities are capable of creating the desired outcomes. An empowering process will rely on the community to define the problem and create viable solutions that are most appropriate for their specific circumstances;
- *Capacity building*: Successful wellness initiatives must be provided for the resources, skills, knowledge and structure in order to meet the defined challenges;
- *Coalitions*: Creating coalitions, often of diverse and competing entities is an essential part of the community engagement process. Building consensus can be daunting, however, the process itself will help define the problem, focus the effort and maximize the efficient use of scarce resources. The concept of mutually beneficial social exchange tells us that individuals and organizations operate, at least in part, on the basis of formal or informal cost/benefit analysis.
- *Community organization*: Community organizing efforts are effective ways of gauging community attitudes, determining appropriate intervention strategies, building grass roots support and mobilizing resources;
- *Stages of innovation*: It is important to recognize that not all communities or individuals within a given community possess the same level of readiness for change at any given time. As in community readiness models, we must match interventions with the community's level of readiness.